§ 8.430.3.A(5)(i): A STATEMENT ASSURING COOPERATION WITH DE-INSTITUTIONALIZATION AND COMMUNITY PLACEMENT EFFORTS.

MCHS-Lakewood is committed to supporting de-institutionalization and community placement efforts for each post-acute patient by:

- Initiating discharge planning on admission and integrating discharge planning into each patient's care plan;
- Providing outcome-based post-acute nursing and rehabilitation care to ensure the patients achieve maximized level of functioning to enable patients to return to the community; and
- Working with community-based resources and hospitals to ensure continuity of care and service integration.

All potential residents will be pre-screened to ensure appropriate placement. If placement is not appropriate, and if the person's condition is such that he can be cared for at home with assistance, the Admissions Director and Social Services Director will refer the person and his family to the appropriate community- based providers. This method will ensure that patients receive post-acute care in the most appropriate setting.

DISCHARGE PLANNING

As a short stay post-acute facility, MCHS-Lakewood's main goal is to maximize independence by returning patients to their community homes as quickly as possible. To accomplish this, MCHS-Lakewood will begin discharge planning for each patient at the time of admission and will incorporate discharge planning into the patient's care plan. When patient discharge is recommended, the patient and family will be given information regarding appropriate community-based services, and MCHS-Lakewood staff will work with the patient and family, and community-based services to ensure a smooth and successful transition back to the community.

Within the first 24-48 hours following admission, the Interdisciplinary Care Team will complete their assessments and will meet with the patient and family to discuss the care plan and goals. The team includes the administrator, director of nursing services, admissions director, social services director, rehabilitation director, and dietician. A comprehensive patient care plan will be completed, outlining the course of treatment and rehabilitation, and the goals for discharge.

The facility will hold weekly utilization meetings where the patient's care plan and achievement of treatment and rehabilitation goals are discussed. If continued stay at the facility is necessary, the admissions director and social worker will meet with the patient and family to review options for extending the stay.

COLLABORATIVE RELATIONSHIPS AND CONTINUITY OF CARE

MCHS-Lakewood intends to be an integral part of the local healthcare delivery system. It will establish collaborative relationships with other health care providers and with community organizations to ensure that individuals seeking post-acute care services receive the appropriate level of care and have access to the entire continuum of care, including community-based services. As part of its efforts to be an integral part of the local healthcare delivery system, MCHS-Lakewood will do the following:

- Establish referral relationships, including expansion of relationships that have already been established by the corporate-related MCHS-Denver on the eastern side of the Denver metro market;

- Develop protocols for collaborative efforts and processes to ensure continuity of patient care and successful re-integration in the community;

- Establish care transition procedures that are specific to the referral source or provider to ensure that these procedures are fully integrated within both organizations;

- Implement procedures to maintain collaborative efforts, including ongoing communications and assessments, and transitions for incorporating new team members; and

- Utilize key HCR ManorCare marketing and operations staff to vertically integrate into the referral organizations in order to create continuity of referral relationships in the event of personnel changes.

In addition, MCHS-Lakewood will pursue collaborative relationships, referral arrangements, and transfer agreements with the following types of service area organizations, including expansion of such relationships that have already been established by MCHS-Denver on the east side of Denver:

- Hospitals
- Physicians
- Home health service
- Homemaker services
- Case management services
- Advocacy groups
- Adult day care
- Meals on Wheels
- Respite care
- Senior centers and recreation groups
- Assisted living facilities
- Retirement communities
- Hospice
- Family Service Groups

Referral relationships with the above providers/organizations will be established through a combination of working agreements and consultant contracts in order to achieve the maximum benefits of service integration for admissions, treatment, referral, and discharge coordination. Nursing facility personnel will become actively involved in local health care and community councils, committees, and special interest groups such as chambers of commerce; Area Agency on Aging; health care association; organizations of specific professions, such as the local branch of Association of Practitioners of Infection Control ("APIC"), Nurse Association, Community Food Service Managers; and special interest groups, such as the local chapter of the Alzheimer's Association. The post-acute facility will be offered as a meeting place for civic organizations, committees, and councils as part of its community integration efforts.

MCHS-Lakewood will maintain transfer agreements with local hospitals to facilitate the transfer of residents between the facility and the hospital, and the provision of emergency, medical, and diagnostic evaluations. MCHS-Lakewood will work with home health agencies to provide follow-up nursing care for residents discharged home from the nursing facility. MCHS-Lakewood will work with advocacy groups and service organizations to promote the availability and accessibility of needed long-term care services. MCHS-Lakewood's relationships with adult day care programs and respite care programs will ensure referrals to alternative health care options if admission to the nursing facility is not appropriate. These linkages are important so that MCHS-Lakewood is recognized as a vital community resource.

By arranging or contracting for non-nursing services, the 120-bed facility will promote the utilization of less intensive, non-institutional services such as home health care, adult day care, meals-on-wheels, assisted living and adult family care. These services will be offered to residents discharged and individuals referred for admission who do not require nursing home services. MCHS-Lakewood will establish linkages with other providers of these services to ensure accessibility and to facilitate transfer for facility residents and potential admissions when needed. These working relationships will also ensure that MCHS-Lakewood is recognized as a community resource and that facility patients have access to the full continuum of post-acute care and community-based support services.

Persons referred to community-based services will be individuals whose needs are better met through home health care, adult day care, assisted living, and other community-based programs. Referrals will also be made for persons inquiring at the facility for standard and specialized services, but whom after pre-screening, are determined to be inappropriate for admission to the facility.

The desired outcomes will be to ensure that (1) a continuum of post-acute services (admissions, treatment, referral, and discharge coordination) are available to service area residents, (2) all residents treated at MCHS-Lakewood are appropriately placed, and that any facility resident capable of functioning with less-intensive care, especially non-institutional care, will be referred to the appropriate resource for transfer and/or appropriate placement, and (3) inappropriate admissions are avoided in order to minimize lifestyle changes to the extent possible.

Key Staff Responsibilities

MCHS-Lakewood's Administrator will be responsible for establishing transfer and referral agreements and consultant contracts with local providers to ensure that linkages are available for admission, treatment, referral, and discharge coordination. Services arranged by these agreements and contracts will be monitored by the Administrator to ensure that they are available when needed. The Administrator and staff from the case management system are responsible for networking with managed care organizations.

The Administrator will be responsible for encouraging facility staff to participate in community and government organizations. The Administrator, Admissions Director, DON, Social Services Director, and Activities Director will be involved with these groups to the extent possible.

Resident medical records will be reviewed by an interdisciplinary team to ensure that transfers are being accomplished and consultant services are being provided in a timely manner. Outcomes will also be monitored through Quality Improvement and Quality of Life Committee reports and state licensure surveys. Medical consultants will be monitored by the administrator through the consultants' submission of monthly reports regarding provision of specific services. Facility staff members will maintain a record of participation in community organizations, meetings, events or activities. These records will be monitored by the Administrator. It is anticipated that participation by nursing facility staff in community activities should result in favorable community perceptions. Resident and family perceptions of the nursing facility and its community support programs will be measured through periodic surveys of guarantor and resident levels of satisfaction with the facility. Resident and family satisfaction with the services provided by the facility should result in increased family participation.

All residents will have the benefit of the interdisciplinary team approach to care planning and formulating discharge goals. The resident will be monitored and reassessed on a regular basis to determine discharge potential. The DON, Social Services Director, and Activities Director will act as liaisons with the resident's family/guarantor to keep them informed on the resident's progress. If the resident improves to the extent that less intensive care is appropriate, the resident and his family will be advised as to the availability of community support systems, such as home health care, adult day care, or other options. The Social Services Director will serve as the liaison between the interdisciplinary team, the resident, his family, and the appropriate provider to coordinate the discharge home and linkage for support services.

The Admissions Director will be responsible for both ensuring that potential residents who inquire for admission to the facility will be referred to the appropriate provider if admission to the facility is not appropriate and coordinating the transfer and referral of individuals to the appropriate health care provider or organization. The Social Services Director, along with other members of the interdisciplinary team, will be responsible for discharge planning to ensure that residents are discharged when appropriate. Through their ongoing work, the Admissions Director and Social Services Director will maintain working relationships with providers of non-institutional services.

The Admissions Director and the Medical Records Clerk will maintain records of inquiries, admissions and referrals, and discharges (with location of resident after discharge). These records will be reviewed through Quality Improvement and Quality of Life Committee reports and licensure surveys to determine if appropriate referrals and discharges are being made. Resident care plans will be reviewed on a regular basis by the interdisciplinary team to determine if discharge is appropriate and if discharge plan goals are being updated and/or modified. Discharge planning will also be monitored through the same reports and licensure surveys. Monitoring of the discharge plans will promote the utilization of less intensive, non-institutional services whenever possible.